



861 Critter Court  
Onalaska, WI 54650  
Phone: 608.783.2292  
Fax: 608.783.1182

## APARTMENT APPLICATION

I/we request the reservation of an apartment within the following area of SpringBrook Community of Onalaska:

- € Independent Living
- € Assisted Living
- € Memory Care / High Acuity

### 1. APPLICANT INFORMATION

Applicant \_\_\_\_\_ M/F DOB \_\_\_/\_\_\_/\_\_\_

Co-Applicant \_\_\_\_\_ M/F DOB \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

Indicate Temporary Address if applicable (nursing home, hospital etc.) \_\_\_\_\_

Health Care Power of Attorney (HCPOA) form completed Y / N (Attach copy to application)

Is HCPOA Activated? Y / N / Unknown

Durable/Financial Power of Attorney form completed Y / N (Attach copy to application)

Applicant Social Security # \_\_\_\_\_ Medicare# \_\_\_\_\_

Co-Applicant Social Security# \_\_\_\_\_ Medicare# \_\_\_\_\_

### 2. REFERRAL SOURCE:

- € Google or other internet browser search
- € SpringBrook Website
- € SpringBrook Facebook Page
- € Print ad in the following newspaper \_\_\_\_\_

€ Hospital or Nursing home (Name) \_\_\_\_\_

€ Current or former tenant (Name) \_\_\_\_\_

€ Current or former employee (Name) \_\_\_\_\_

€ Family / Friend (Name) \_\_\_\_\_

€ Other \_\_\_\_\_

**3. SOCIAL HISTORY:**

Applicant Occupation prior to retirement: \_\_\_\_\_

Co-Applicant Occupation prior to retirement: \_\_\_\_\_

Current Marital Status:

€ Married

€ Widowed

€ Divorced

€ Single

If married, number of years and anniversary date: \_\_\_\_\_

Religion \_\_\_\_\_

Military Status \_\_\_\_\_

Education \_\_\_\_\_

Children \_\_\_\_\_

Applicant Interests, Hobbies, Awards, Accomplishments: \_\_\_\_\_

Co-Applicant Interest, Hobbies, Awards, Accomplishments: \_\_\_\_\_

**4. MEDICAL INFORMATION:**

Please list the names of health care professionals who will be serving you, and co-applicant, if applicable:

Primary Physician \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Dentist \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Optometrist \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**5. EMERGENCY CONTACTS:**

**Primary**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email \_\_\_\_\_

**Secondary**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email \_\_\_\_\_

I certify that the information contained within this application is a true and complete statement of fact. By completing this application I/we acknowledge and understand the following:

- This is an application, not a guarantee of admission.
- Financial eligibility is also required. This information must be submitted on a separate form and requires provision of verification documents.
- An admission evaluation must first be completed by a qualified SpringBrook representative for the purpose of determining appropriateness to occupy the apartment of choice. SpringBrook will attempt to honor a request for a specific apartment, however apartment assignments may change based on applicant need, results of evaluation, physician orders, availability, and other factors. If it is determined that the apartment of choice is not appropriate, SpringBrook staff will recommend a different living situation that is safer and more appropriate.
- SpringBrook is not able to hold an apartment reservation for longer than two months; should evaluation or move in take longer than this, SpringBrook may need to cancel or change my reservation.
- At the admission evaluation, SpringBrook will determine the need for additional services above and beyond the base apartment rate. These costs will be added to the monthly bill.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Co-Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Healthcare POA Signature \_\_\_\_\_ Date \_\_\_\_\_

Financial POA Signature \_\_\_\_\_ Date \_\_\_\_\_

SpringBrook Rep. Signature \_\_\_\_\_ Date \_\_\_\_\_

<p><i>Office Use Only:</i> Move-In Specials (if applicable):</p>
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